Full Time Member Benefit Waiver

AmeriCorps Agency, fax this completed form <u>and</u> a copy of the health insurance card if member already has coverage to Julie Hibben at 515-281-4535.

- ❑ **I waive the following coverage because I am not a full-time member**

Agency Name: _____

Member Name: _____

Member Email: _____

Member Phone: _____

Date: _____

I waive health coverage for myself. Please indicate one of the following reasons:

- ❑ I have coverage under another health care benefit plan.
  (Please provide a copy of your health insurance card)

- ❑ I do not wish to enroll in the health care plan.

I would like the health insurance for myself and I am not on any other insurance health coverage.

- ❑ Yes, I want coverage
  You will be directed to the Willis Group

I would like more information on the AmeriCorps Child Care Benefit Program in accordance to their Member Eligibility Requirements.

- ❑ Yes, I would like information.